



**INSTRUCTIONS:** As required by, **16 Del. C. § 903 and 904** "Any person, agency, organization or entity who knows or in good faith suspects child abuse or neglect shall make a report in accordance with § 904 of this title. For purposes of this section, 'person' shall include, but shall not be limited to, any physician, any other person in the healing arts including any person licensed to render services in medicine, osteopathy or dentistry, any intern, resident, nurse, school employee, social worker, psychologist, medical examiner, hospital, health care institution, the Medical Society of Delaware or law-enforcement agency. In addition to and not in lieu of reporting to the Division of Family Services, any such person may also give oral or written notification of said knowledge or suspicion to any police officer who is in the presence of such person for the purpose of rendering assistance to the child in question or investigating the cause of the child's injuries or condition. Any report of child abuse or neglect required to be made under this chapter shall be made to the Department of Services for Children, Youth and Their Families. An immediate oral report shall be made by telephone or otherwise. Reports and the contents thereof including a written report, if requested, shall be made in accordance with the rules and regulations of the Division, or in accordance with the rules and regulations adopted by the Division."

Within 72 hours after the oral report, send a completed Child Abuse/Neglect Mandatory Reporting Form to the address below. Please type or print the information and sign the form on the back.

**DIVISIONS OF FAMILY SERVICES - STATE OF DELAWARE**

3601 North Dupont Highway  
New Castle, DE 19720-6315

**IDENTIFYING INFORMATION**

<b>Child's Name (Last, First, Initial)</b>	<b>Date of Birth/ Age</b>	<b>Sex</b>	<b>Race</b>	<b>Victim (Yes/No)</b>
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1. \_\_\_\_\_

Current Address: \_\_\_\_\_

2. \_\_\_\_\_

Current Address: \_\_\_\_\_

3. \_\_\_\_\_

Current Address: \_\_\_\_\_

4. \_\_\_\_\_

Current Address: \_\_\_\_\_

5. \_\_\_\_\_

Current Address: \_\_\_\_\_

<b>Parents'/Custodians'/Caretakers' Names (Last, First, Initial)</b>	<b>Date of Birth/ Age</b>	<b>Sex</b>	<b>Race</b>	<b>Perpetrator (Yes/No)</b>
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**Mother**

6. \_\_\_\_\_

Current Address: \_\_\_\_\_

**Father**

7. \_\_\_\_\_

Current Address: \_\_\_\_\_

**Custodian/Caretaker (Relationship)**

8. \_\_\_\_\_

Current Address: \_\_\_\_\_

Please specify for numbers 1 - 8 above:

Foreign language spoken: #s \_\_\_\_\_ Specify type: \_\_\_\_\_

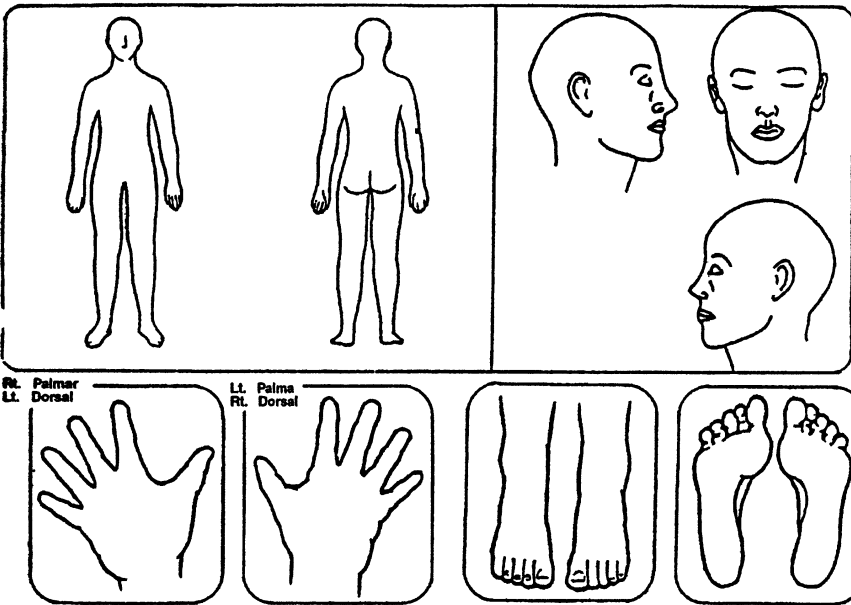
Disabilities: #s \_\_\_\_\_ Specify type: \_\_\_\_\_

## DESCRIPTION

1. Describe the child's current condition/injuries and the reason you suspect abuse/neglect. Include evidence, if known, of prior abuse and/or neglect to this child or sibling. Add pages or attach further written documentation as needed.

2. If applicable, note the exact location of any injury by placing a number on the model below. Use the lines to the right of the models to describe the corresponding injury that each number represents. Check the category of injuries below.

\_\_\_\_\_ Physical Abuse      \_\_\_\_\_ Sexual Abuse      \_\_\_\_\_ Physical Neglect



- ### 3. Actions taken "T" or pending "P"

\_\_\_\_\_ Medical Examination

## X-Rays

           Photographs

\_\_\_\_ Notification of Police

\_\_\_\_ Notification of Medical Examiner

Other: \_\_\_\_\_

**REPORTING SOURCE (CONFIDENTIAL)**

*Signature*

Title or Relationship to Child

Date of Report

Facility/Organization

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*Address*

Telephone No.

**REPORT LINE USE ONLY**

Date of Oral Report: \_\_\_\_\_

Report was: \_\_\_\_\_ Accepted \_\_\_\_\_ Rejected

Date Written Report Received: \_\_\_\_\_

Prior DFS Case Activity/Reports? ☐ Yes ☐ No If "yes", specify dates: \_\_\_\_\_